STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185246	A. BUILDING _____ B. WING _____	C 05/21/2010

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F 000	INITIAL COMMENTS An abbreviated standard survey (KY14771) was conducted on May 19-21, 2010. Deficient practice was identified at a "D" level.	F 000	***Rockcastle health and Rehabilitation, a Signature Healthcare Facility does not believe and does not admit that any deficiencies existed, either before, during or after the survey. The Facility reserves all rights to contest the survey finding through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the Facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should consider as a waiver of any potentially applicable peer Review, Quality assurance or self critical examination privilege which the Facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. The Facility offers its response, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents.***	
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to maintain housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Resident #1's Broda chair was observed to be soiled and in need of cleaning on May 19, 2010. The findings include: A review of resident #1's medical record revealed the resident was admitted to the facility on August 22, 2008. Further review of resident 1's medical record revealed the resident was seen by the physician on May 10, 2010, related to rash-like areas on resident #1's buttocks, back, and shoulder areas that were causing the resident to scratch intensely, creating open areas. A review of a physician's progress note dated May 5, 2010, revealed the resident had been diagnosed with dermatitis, pruritus, and very dry skin with cellulitis. The progress note also revealed the resident was to receive daily baths. Additionally, an interview with resident #1's physician on May 19, 2010, at 10:40 a.m., revealed a definitive	F 253	**F 253 483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES** **1.** Resident #1's Broda chair has been cleaned to ensure that the resident maintains a sanitary, orderly, and comfortable environment. This was	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Richard Ramsey — TITLE: Administrator — (X6) DATE: 6/9/2010

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 253	Continued From page 1 diagnosis for resident #1's "rash" could not be made. The physician stated oral and topical medications ordered for the resident would "hopefully" resolve the problem, and further stated that the resident needed daily baths, and care equipment utilized by the resident should be kept clean. A review of resident #1's current comprehensive care plan revealed the problem of skin infection was added on May 10, 2010; interventions to be utilized for the problem revealed "good clean hygiene techniques" were to be utilized for resident #1. An observation on May 19, 2010, at 9:50 a.m., revealed the resident to be in bed, and a Broda chair was present in the resident's room. Further observation of the Broda chair revealed a buildup of dirt and food particles in the corners of the chair seat and the frame, seat, and arms of the chair were observed to be soiled and in need of cleaning. An interview and subsequent observation of resident #1's Broda chair was conducted on May 19, 2010, at 9:55 a.m., with LPN #1 who was caring for resident #1. LPN #1 confirmed that resident #1's Broda chair was soiled and in need of cleaning, however, LPN #1 stated he/she had failed to notice the chair was soiled until pointed out by the surveyor. The LPN stated resident care equipment was to be cleaned by third shift staff, but was unaware of the last time resident #1's Broda chair had been cleaned. An interview with the Administrator and Director of Nursing (DON) conducted on May 19, 2010, at 3:30 p.m., revealed the facility had no cleaning	F 253	completed on 5/21/2010 by the Environmental Services Director. 2. The Administrator, Director of Nursing, Director of Housekeeping, and Director of Maintenance made environmental rounds throughout the entire facility to include resident's rooms in order to observe the following: Cleanliness, infection control, equipment in need of repair, equipment functionality, as well as any other areas recognized for improvement. Concerns identified were corrected immediately, or those that are not of harm were placed on an action plan and prioritized with dates of completion. Environmental rounds were completed 6/15/2010. 3. Equipment for residents is being cleaned to ensure that all residents maintain a sanitary, orderly, and comfortable environment. Cleaning equipment is being completed by the Administrator, Plant Operations Team, Environmental Services Director, and Nursing Staff Members. All equipment will be cleaned by 06/17/2010. A facility schedule is being established to ensure that resident equipment will be cleaned on a routine basis. This scheduled is being developed by the Director of Nursing and Administrator to be implemented by 06/17/2010. The Unit Managers, Director of Nursing, and Administrator will monitor the	

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F 253	Continued From page 2 schedule in place for resident care equipment , and was unaware of the last time resident #1's Broda chair had been cleaned.	F 253	cleanliness of equipment during daily rounds to ensure that residents maintain a sanitary, orderly, and clean environment.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of	F 441	All licensed nurses and SRNA's are being in-serviced regarding the process and schedule for cleaning resident equipment. This in-service will also include the process for reporting equipment in need of cleaning to ensure residents are being provided equipment that is sanitary, orderly, and clean. All other staff members will be in-serviced regarding the process for reporting equipment in need of cleaning, along with the importance of observing all aspects of the residents environment, including equipment, when making daily rounds in resident rooms and observing residents on unit. These in-services will be provided by the Administrator and Staff Development Coordinator to be completed on 06/11/2010. 4. The Administrator, Director of Nursing, Unit Managers, Staff Development Coordinator and Environmental Services Director will monitor the cleanliness of resident equipment through auditing 20% of residents monthly to ensure that equipment is being cleaned according to schedule. This review will be reported to the Quality Assurance Committee monthly for three months, for recommendations and further follow-up as indicated. Any areas of concern will	

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F 441	Continued From page 3 infection. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain infection control practices to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection. Observations of resident #1's Broda chair on May 19, 2010, revealed the chair was dirty and in need of cleaning. The findings include: During an initial tour of the facility on May 19, 2010, at 9:00 a.m., resident #12 was observed to be lying in bed, awake and alert. Resident #12 requested the surveyor to summon assistance due to the resident's need to void. A facility staff person was notified of the resident request and immediately entered the resident's room. A subsequent observation and interview with resident #12 on May 19, 2010, at 9:20, a.m., revealed the resident to be in bed, and a strong offensive odor was present upon entering the resident's room. Resident #12 voiced that he/she had been assisted to the bedside toilet, and assisted back to bed, revealing he/she was unable to transfer/ambulate without staff assistance. Further observation of the bedside toilet in the resident's room revealed a large amount of urine and stool present in the toilet. An interview was conducted on May 19, 2010, at 9:25 a.m., with Certified Nursing Assistant (CNA)	F 441	be addressed immediately. **F441 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS** **1.** Resident #1's Broda chair has been cleaned to ensure that the resident maintains a sanitary, orderly, and comfortable environment. This was completed on 5/21/2010 by the Environmental Services Director. The sink in the central bath on Indian Trails was disinfected May 21, 2010 to ensure infection control practices are maintained and residents are provided a safe, sanitary and comfortable environment for residents. Resident #12's bedside toilet is being emptied in the hopper room located on Indian Trails to ensure that infection control practices are maintained. **2.** The Administrator, Director of Nursing, Director of Housekeeping, and Director of Maintenance made environmental rounds throughout the entire facility to include resident's rooms in order to observe the following: Cleanliness, infection control, equipment in need of repair, equipment functionality, as well as any other areas recognized for improvement. Concerns identified were corrected immediately, or those that are	6/17/10

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F 441	Continued From page 4 #1, who was caring for resident #12. CNA #1 stated that he/she had assisted resident #12 to the bedside toilet and back to bed upon the resident's request. The CNA further revealed that he/she had failed to empty the bedside toilet after the resident utilized it. Further observation of CNA #1 on May 19, 2010, at 9:30 a.m., revealed CNA #1 proceeded to empty resident #12's bedside toilet by placing a towel over the receptacle container, removing it from the base of the bedside toilet, and taking it to the central bathroom located next to resident #12's room. CNA #1 then disposed of the container's contents by pouring the contents into the toilet and flushing. CNA #1 then attempted to rinse out the container utilizing water from the faucet of the bathtub that was present in the central bathroom. However, the faucet handles for both the hot and cold water taps of the bathtub spun freely when CNA #1 attempted unsuccessfully to obtain water from the bathtub. CNA #1 then proceeded to obtain water from the hand sink by placing the soiled bedside toilet receptacle in the sink basin, running water into the receptacle, removing the receptacle from the sink basin, and pouring the water into the toilet. CNA #1 then proceeded to place the receptacle back on the bedside toilet in the resident's room. CNA #1 took no further action to clean/disinfect the hand sink in the central bath. An interview was conducted on May 19, 2010, at 9:35 a.m., with CNA #1. CNA #1 stated she only worked at the facility on a PRN (as needed) basis, and had not realized the water in the bathtub had not worked, and the only other source of water in the bathroom was the hand sink. CNA #1 went on to explain that if bedside	F 441	not of harm were placed on an action plan and prioritized with dates of completion. Environmental rounds were completed 6/15/2010. 3. Equipment for residents is being cleaned to ensure that all residents maintain a sanitary, orderly, and comfortable environment. Cleaning equipment is being completed by the Administrator, Plant Operations Team, Environmental Services Director, and Nursing Staff Members. All equipment will be cleaned by 6/17/2010. A facility schedule is being established to ensure that resident equipment will be cleaned on a routine basis. This scheduled is being developed by the Director of Nursing and Administrator to be implemented 6/17/2010. The Unit Managers, Director of Nursing, and Administrator will monitor the cleanliness of equipment during daily rounds to ensure that residents maintain a sanitary, orderly, and clean environment. Licensed nurses and SRNA's are being in-serviced regarding the process and schedule for cleaning resident equipment. This in-service will also include the process for reporting equipment in need of cleaning to ensure residents are being provided equipment that is sanitary, orderly, and clean. All other staff members will be in-serviced regarding the process for reporting	

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F 441	Continued From page 5 toilet containers/bedpans were not emptied in the central bathroom on the Indian Trails hallway the soiled containers would have to be carried to the shower room on the new addition hallway, or transport the soiled containers through the dining room, and past the kitchen's food distribution center to the other resident hall which had a central bathroom. CNA #1 stated she had never thought of washing/disinfecting the hand sink after having placed the soiled receptacle into it and obtaining water. CNA #1 also confirmed that many residents who reside on the Indian Trails hallway utilize the hand sink for washing their hands, face, and oral hygiene, due to the majority of the rooms on the hallway not having a sink/toilet facilities in their rooms. Additionally, CNA #1 revealed that he/she had received no training regarding the facility's infection control practices, or how/where to dispose/clean toilet receptacles/bedpans. An additional interview was conducted with CNA #2 who was working on the Indian Trails hallway with CNA #1 on May 19, 2010, at 9:40 a.m., who stated that he/she also utilized the hand sink in the central bath to obtain water for rinsing soiled toilet receptacles/bedpans. An interview was conducted on May 19, 2010, at 9:40 a.m., with the Administrator, who stated the water in the bathtub of the central bath had been disabled at his/her direction approximately nine months ago due to being "afraid it created a safety risk for residents." A subsequent interview was conducted on May 19, 2010, at 3:30 p.m., with the Director of Nursing (DON) and Administrator. The DON stated she had not been aware that the bathtub water had been disabled, and had never	F 441	equipment in need of cleaning, along with the importance of observing all aspects of the residents environment, including equipment, when making daily rounds in resident rooms and observing residents on unit. These in-services will be provided by the Administrator and Staff Development Coordinator to be completed on 6/11/2010. All centrally located bathrooms, and resident personal bathrooms, have been cleaned to ensure that residents are provided a sanitary environment. All bedside toilets and bedpans are being emptied and cleaned in the hopper room on the hall where the resident resides when a private resident bathroom is unavailable. Licensed nurses and SRNA's are being in-serviced regarding infection control practices, the process for emptying/disinfecting bedside toilets and bedpans, and the appropriate location for emptying containers containing urine and/or stool. This education will additionally include the locations of hopper rooms throughout the facility as well as the equipment available for use in each hopper room and central bath. This in-service will be completed by the Staff Development Coordinator and Unit Managers on 6/11/2010.	

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F 441	Continued From page 6 considered and was unaware of how toilet receptacles/bedpans were being cleaned on the Indian Trails hallway. The DON and Administrator stated that the facility had no policy/procedure in place regarding emptying/cleaning toilet receptacles/bedpans.	F 441	**4.** **The Administrator, Director of Nursing, Unit Managers, Staff Development Coordinator and Environmental Services Director will monitor the cleanliness of resident equipment through auditing 20% of residents monthly to ensure that equipment is being cleaned according to schedule. Daily observations of resident care areas, to include central bath, hopper room(s), and resident bathrooms will be completed to ensure that infection control practices are being maintained by staff members. Monitoring of these areas will include 20 direct observations monthly. The above reviews will be reported to the Quality Assurance Committee monthly for three months, for recommendations and further follow-up as indicated. Any areas of concern will be addressed immediately.**	**6/17/10**